STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF CARMEL	11610 TECHNOLOGY DR CARMEL, IN 46032

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R000000	This visit was for the State Residential Licensure Survey. Survey dates: August 26, 27 and 28, 2014. Facility number: 012309 Provider number: 012309 AIM number: N/A Survey team: Sandra Nolder, RN Census bed type: Residential: 31 Total: 31 Census payor type: Medicaid: 24 Other: 7 Total: 31 Sample: 8 These state findings are cited in accordance with 410 IAC 16.2-5. Quality Review was completed by Tammy Alley RN on September 2, 2014.	R000000	Submission of this plan of correction does not constituteadmission or agreement by the provider of the truth of facts alleged orcorrection set forth on the statement of deficiencies. This plan of correctionis prepared and submitted as a requirement under state and federal law. Pleaseaccept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for the surveyending August 28, 2014. Respectfully, Stuart Reed Administrator	
R000117	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure there was adequate First Aid and CPR (Cardiopulmonary Resuscitation) certified staff to cover all shifts. This deficient practice had the potential to affect 31 of 31 residents residing in the facility. Findings include: The employee records were reviewed on 8/28/14 at 11:00 A.M. The records indicated the facility had 6 out of 12	R000117	1.No residents were harmed. The facility did ensure there was adequate CPR certified staff to cover all shifts. A First Aid certification class is scheduled for nursing staff. 2.All employee certifications were reviewed; any nursing staff members without a CPR and/or First Aid certification will be required to attend a CPR and First Aid class. Thus the facility will ensure there is adequate CPR and First Aid certified staff to cover all shifts. 3.As a measure of ongoing compliance the	09/12/2014

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	regularly scheduled employees certified in CPR and First Aid. The employee schedule as worked for 8/17/14 through 8/31/14 was reviewed. The schedule indicated there were no First Aid and CPR certified staff working for the following shifts: 8/17/14--10 P.M.-6 A.M. 8/18/14--2 P.M.-10 P.M. and 10 P.M.-6 A.M. 8/19/14--2 P.M.-10 P.M. and 10 P.M.-6 A.M. 8/20/14--2 P.M.-10 P.M. and 10 P.M.-6 A.M. 8/21/14--2 P.M.-10 P.M. and 10 P.M.-6 A.M. 8/22/14--2 P.M.-10 P.M. and 10 P.M.-6 A.M. 8/23/14--6 A.M.--2 P.M., 2 P.M.-10 P.M. and 10 P.M.-6 A.M. 8/24/14--2 P.M.-10 P.M. and 10 P.M.-6 A.M. 8/25/14--2 P.M.-10 P.M. and 10 P.M.-6 A.M. 8/26/14--2 P.M.-10 P.M. and 10 P.M.-6 A.M. 8/27/14--2 P.M.-10 P.M. and 10 P.M.-6 A.M. 8/28/14--2 P.M.-10 P.M. and 10 P.M.-6 A.M. 8/29/14--2 P.M.-10 P.M. and 10 P.M.-6 A.M. 8/30/14--10 P.M.-6 A.M.		Administrator/Directoror designee will complete an audit of the upcoming monthly schedule ongoing to ensure the facility has adequate CPR and First Aid certified staff to cover all shifts, (please see attachment A). 4.As a measure of quality assurance the Administrator/Director or designee will complete said audits monthly ongoing. Should a deficient practice be noted, immediate corrective action will be taken. The plan ofcorrection will be revised accordingly, if warranted.	

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	8/31/14--10 P.M.-6 A.M. During an interview on 8/28/14 at 2:20 P.M., the Director of Nursing indicated the schedule that was reviewed was the current as worked schedule. She indicated she was informing the Executive Director and Nurse Consultant that there was not enough First Aid and CPR certified staff to cover each shift for every 24 hour period.			
R000121	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks			

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	after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			
	Based on interview and record review, the facility failed to ensure a Chest X-ray was completed to rule out the presence of Tuberculosis after a positive PPD (Mantoux) test for 1 of 10 employees reviewed for PPD tests. (LPN #1) Findings include: The employee records were reviewed on 8/28/14 at 11:00 A.M. The records indicated that 1 out of 5 new employees who had PPD tests completed tested positive. LPN #1's date of hire was 2/25/14 and she had her first step PPD test completed on 2/27/14. The PPD record indicated she tested positive. The PPD test record indicated she was sent for a chest X-ray on 2/28/14. LPN #1's employee file lacked a Chest X-ray	R000121	1.No residents were harmed. LPN#1 had a tuberculosis risk assessment completed upon the 10mm reaction to the tuberculin skin test, which indicated no symptoms of tuberculosis. LPN#1 had a CXR completed which indicated no active disease. 2.All employee files were reviewed to ensure all staff received tuberculin skin tests as required. Any positive results were audited to ensure a CXR was completed as well. Facility Managers will be in-serviced on the hiring process regarding tuberculin skin testing and CXR requirements, (please see attachment B). 3.As a measure of ongoing compliance the Administrator/Director or designee will complete an audit monthly ongoing to confirm all staff received tuberculin skin tests	09/12/2014

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	result. During an interview on 8/28/14 at 2 P.M., the Director of Nursing (DoN) indicated LPN #1 did have a positive PPD test on 2/27/14. She indicated LPN #1 was sent to a medical facility on 2/28/14 to get a Chest X-ray, but she wanted to save money so she attempted to get her Chest X-ray result from (name of facility). DoN indicated LPN #1 had problems obtaining her Chest X-ray results from the other facility and she had not gotten her Chest X-ray until today.		and CXR as required, (please see attachment C). 4.As a measure of quality assurance the Administrator/Directoror designee will complete said audits monthly ongoing. Should a deficient practice be noted, immediate corrective action will be taken. The plan ofcorrection will be revised accordingly, if warranted.	
R000214	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to evaluate the individual needs related to a significant weight loss for 1 of 6 residents reviewed for evaluation of individual needs regarding substantial changes in a sample of 6. (Resident # 102) Findings include:	R000214	1.Resident #102 was affected. The physician and responsible party were notified of the weight changes and orders were followed. 2.All residents with weight changes have the potential to be affected. All nurses and QMA's will be in-serviced on weight monitoring (at a minimum upon admission and semi-annually thereafter-unless the resident	09/12/2014

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	Resident #102's record was reviewed on 8/26/14 at 3:46 P.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, pneumonia, chronic pain, anemia, depression, gastroesophageal reflux disease and osteoarthritis. The "Vital Sign & Weight Flow Sheet" record had documentation of monthly weights as follows: January 2014--141 February 2014--140 March 2014--133 April 2014--130 May 2014--132 June 2014--134 July 2014--133 August 2014--127 An "Interdisciplinary Progress Note" dated 3/31/14 at 4 P.M., indicated "Weight loss noted, MD + [and] family notified, possibly D/t [due to] hx [history] of edema Continue to monitor weights monthly Res [resident] continues to eat well." An evaluation of the resident's weight loss over the last seven months, to determine individual needs related to the weight loss was not found in the resident's record.		desires/agrees to more frequent monitoring) and use of 24 hour report sheets as well as physician, responsible party and registered dietitian notification, (please see attachment D). 3.As a measure of ongoing compliance the DON will complete an audit tool monthly ongoing to ensure weights obtained are reviewed, the physician, responsible party and registered dietician are notified as indicated, and the Service Plan/Evaluation of Individual Resident Needs is updated with any substantial changes in the resident's condition, as the rule requires weight taken on admission and semi-annually thereafter (please see attachment E). 4.As a means of quality assurance the DON or designee will complete the above described monitoring monthly ongoing. Should a deficient practice be observed, immediate corrective action will be taken. Additionally, the Administrator/Director or designee will monitor and sign off on the audit tool monthly ongoing. The plan of correction will be revised accordingly, if warranted.	

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	A "Level of Service Assessment/Evaluation-Full List of Items" dated 1/31/14 and 7/7/14, indicated the resident "Can feed self, chew and swallow foods without difficulty...." An Admit Nutritional Progress Note dated 10/1/13, was found in the resident's record and indicated the resident was on a regular diet. She received multivitamin, calcium supplement, iron supplement, vitamin D3 and Lasix. The Registered Dietician (RD) indicated there were no recommendations and she would follow her. No further RD notes were found in the resident's record. Further information regarding the resident's weight loss was requested from the Executive Director (ED), Director of Nursing (DoN) and Nurse Consultant (NC) during the Daily Conference on 8/26/14. During an interview on 8/27/14 at 10 A.M., the Nurse Consultant indicated the weights were sent to the RD every month and she should have been looking at the resident regarding the weight loss from 140 to 133 pounds in a month, since it was a significant weight loss. She indicated the Physician was notified and			

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	there was no new orders. She indicated the resident's individual needs were not re-evaluated regarding the resident's significant weight loss. A current policy titled "EVALUATION OF INDIVIDUAL RESIDENT NEEDS" undated, provided by the Executive Director on 8/27/14 at 9:45 A.M., indicated "Policy:..Said assessments will be updated quarterly. More frequent assessments will be performed upon the resident's request or at the time of a known substantial change in the resident's condition. Assessments will address the resident's physical/mental status, independence with activities of daily living and weight...."			
R000217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and			

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	(D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to update a resident's service plan related to a significant weight loss for 1 of 6 residents reviewed for updating service plans for substantial changes in a sample of 6. (Resident # 102) Findings include: Resident #102's record was reviewed on 8/26/14 at 3:46 P.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, pneumonia, chronic pain, anemia, depression, gastroesophageal reflux disease and osteoarthritis.	R000217	1.Resident #102 was affected. The physician and responsible party were notified of the weight changes and orders were followed. 2.All residents with weight changes have the potential to be affected. All nurses and QMA's will be in-serviced on weight monitoring (a minimum of on admission and semi-annually as per rule unless more frequent monitoring agreed to and/or desired by the resident) and use of 24 hour report sheets as well as physician, responsible party and registered dietitian notification, (please see attachment D). 3.As a measure of ongoing compliance the DON will complete an audit tool monthly of	09/12/2014

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	The "Vital Sign & Weight Flow Sheet" record had documentation of monthly weights as follows: January 2014--141 February 2014--140 March 2014--133 April 2014--130 May 2014--132 June 2014--134 July 2014--133 August 2014--127 An "Interdisciplinary Progress Note" dated 3/31/14 at 4 P.M., indicated "Weight loss noted, MD + [and] family notified, possibly D/t [due to] hx [history] of edema Continue to monitor weights monthly Res [resident] continues to eat well." The resident's record lacked an updated Service Plan for a significant weight loss that occurred from February 2014 to March 2014 with a continued weight loss into August 2014. An "EVALUATION OF NEEDS/SERVICE PLAN" dated 1/31/14 and 7/7/14, indicated "Feeding or Eating: Ability to feed self meals and snacks: Able to independently feed self. Both Service Plan documents lacked information regarding the resident's significant weight loss from February		applicable weights obtained and ongoing to ensure weights obtained are reviewed, the physician, responsible party and registered dietician are notified as indicated, and the Service Plan/Evaluation of Individual Resident Needs is updated with any substantial changes in the resident's condition, (please see attachment E). 4.As a means of quality assurance the DON or designee will complete the above described monitoring monthly ongoing. Should a deficient practice be observed, immediate corrective action will be taken. Additionally, the Administrator/Director ordesignee will monitor and sign off on the audit tool monthly ongoing. The plan of correction will be revised accordingly, if warranted.	

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	2014 to March 2014 and her continued weight loss into August 2014. An Admit Nutritional Progress Note dated 10/1/13, was found in the resident's record and indicated the resident was on a regular diet. She received multivitamin, calcium supplement, iron supplement, vitamin D3 and Lasix. The Registered Dietician (RD) indicated there were no recommendations and she would follow her. No further RD notes were found in the resident's record. Further information regarding the resident's weight loss was requested from the Executive Director (ED), Director of Nursing (DoN) and Nurse Consultant (NC) during the Daily Conference on 8/26/14. During an interview on 8/27/14 at 10 A.M., the Nurse Consultant indicated the weights were sent to the RD every month and she should have been looking at the resident regarding the weight loss from 140 to 133 pounds in a month, since it was a significant weight loss. She indicated the Physician was notified and there was no new orders. She indicated the Service Plan was not updated regarding the resident's significant weight loss.			

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	During an interview on 8/28/14 at 3 P.M., the Director of Nursing indicated she used the Evaluation of Needs/Service Plan and the Level of Service Assessment/Evaluation as the Service Plan for the residents. A current policy titled "EVALUATION OF INDIVIDUAL RESIDENT NEEDS" undated, provided by the Executive Director on 8/27/14 at 9:45 A.M., indicated "Policy:..Said assessments will be updated quarterly. More frequent assessments will be performed upon the resident's request or at the time of a known substantial change in the resident's condition. Assessments will address the resident's physical/mental status, independence with activities of daily living and weight... Upon completion of an evaluation/assessment, the facility, using the appropriately trained staff, shall identify and document the services provided to the resident by the facility, in the form of a service plan, as follows. Procedure: 1. The services offered to the individual resident shall be appropriate to the scope, frequency, need and preference of the resident...."			

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R000241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview and record review, the facility failed to ensure medication was not left in a resident's apartment for 1 of 8 resident's being reviewed for medications left in a resident's apartment. (Resident #413) Findings include: During a resident interview on 8/27/14 at 11:03 A.M., Resident #413 was observed to pick up a white soufflé cup, shake it and set it back down on the foot stool in front of her next to a glass of water in a Styrofoam cup. When she shook the soufflé cup, something rattled inside. At that time, the resident indicated she had	R000241	1.Resident #413 was not harmed. Immediately upon notification the QMA returned to the resident room and noted that the resident did not feel like taking her medications. The medications were then removed and disposed of. The physician and responsible party for the resident were notified. The QMA was immediately re-educated on the facility's medication administration policy. 2.All residents requiring medications to be administered by staff have the potential to be affected. All nurses and QMA's were re-educated on the facility's policy on Medication Administration. The DON or designee has completed medication administration	09/12/2014

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	not taken her morning pills yet, but she probably had better take them. The resident at that time picked up the soufflé cup, looked in it and set it down on the footstool. She indicated at that time, "The girl brought me my pills about 8 this morning, but I didn't feel like taking them yet because old Arthur was bothering me, so I put them here to take later." The resident pointed to her footstool. She indicated, "She even brought me a glass of water to take my pills with." On 8/27/14 at 11:03 A.M., a white soufflé cup was observed with 10 pills in it. The cup contained a large oval shaped white pill, a blue pill, a red pill and 7 other white pills in the soufflé cup setting next to the glass of water in the Styrofoam cup. During an interview on 8/27/14 at 11:15 A.M., QMA (Qualified Medication Aide) #2 indicated she had given Resident #413 her morning medications at approximately 8:30 A.M., and she had watched her place the medication cup up to her mouth, then she went to get the residents inhalers. QMA #2 indicated the resident must not have taken the medications, but she thought the resident had.		observations on all nurses and QMA's with satisfactory performance noted. 3.As a measure for ongoing compliance the DON or designee will complete medication administration observations at varied times on varied shifts, (see attachment F) weekly for four weeks, then every two weeks for four weeks, then monthly ongoing. 4.As a measure of quality assurance the DON or designee will complete the above described monitoring ongoing. Should a deficient practice be observed, immediate corrective action will be taken. The plan of correction will be revised accordingly, if warranted. The Administrator/Directoror designee will monitor and sign off on the monitoring tools on a monthly basis ongoing.	

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	On 8/27/14 at 11:20 A.M., QMA #2 was observed to knock on the resident's door and the resident let her into her apartment. QMA #2 obtained the cup of medications off the footstool and indicated at that time these medications were the resident's morning medications. At that time the resident indicated she was going to take the medications and QMA #2 instructed the resident it was to late to take the medications and she would receive more tonight. QMA #2 was observed placing the medication in the sharps box on the medication cart. At that time QMA #2 indicated the resident had gotten up to go to the bathroom and must not have taken her medications. She indicated she had not observed her taking the medications. Resident #413's record was reviewed on 8/27/14 at 12:32 P.M. Diagnoses included, but were not limited to, cerebrovascular accident, chronic atrial fibrillation, diabetes mellitus type II, hypertension, congestive heart failure, vascular dementia, depression, and osteoarthritis. A (MAR) Medication Administration Record dated August 2014, included, but were not limited the following Physician orders:			

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	7/18/14--Burpopion SR (sustained release) (An Antidepressant medication) 150 mg (milligrams) take one tablet by mouth daily for diagnosis of depression. 7/18/14--Digoxin (An Inotropic medication used to treat atrial fibrillation) 250 mcg (micrograms) take one tablet by mouth daily for diagnosis of atrial fibrillation. Hold if heart rate below 60. 7/18/14--Diltiazem ER (Extended release) (An Antianginal medication) 240 mg give one table by mouth daily for diagnosis atrial fibrillation. 7/18/14--Claritin (An Antihistamine medication) 10 mg give one tablet by mouth daily for diagnosis of allergies. 7/18/14--Multivitamin (A supplement medication) give one tablet by mouth daily for diagnosis of supplement. 7/18/14--Sertraline HCL (Hydrochloride) (An Antidepressant medication) 50 mg give one tablet by mouth daily for diagnosis of depression / anxiety. 7/18/14--Metformin (A Hypoglycemic medication) 500 mg give one tablet by mouth two times daily for diagnosis diabetes mellitus. 7/18/14--Potassium Cl (Chloride) ER (An electrolyte supplement medication) 20 meq (millieqivalents) give one tablet by mouth two times daily for diagnosis supplement. 7/18/14--Acetaminophen (Tylenol) (A non-narcotic pain medication) 325 mg			

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	give two tablets (650 mg) by mouth every six hours as needed for pain. 8/27/14--Medications to be administered and observed and to be taken, by staff. A document titled "PRN Medication Flow Sheet" indicated on 8/27/14 at 9 A.M., the resident was given Tylenol (Acetaminophen) 325 mg times 2 tablets (650 mg) by QMA #2 for a pain level of 7 on a pain level of 0 to 10. The medication was effective for pain relief at 10 A.M. The line that the medication was documented on this form had a line drawn through it with a message written that indicated "ERROR." An "EVALUATION OF NEEDS/SERVICE PLAN" dated 7/18/14, indicated in the Management of Oral Medications section that the resident was unable to take medications unless administered by someone else. A "Level of Service Assessment/Evaluation" dated 7/17/14, indicated for the judgment section that the resident marked poor decisions and required cueing and supervision in planning, organizing and correcting her daily routines. The memory section indicated she required cueing less than three times in a seven day period. The medications procedures section indicated			

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	the resident had to have her medications administered by caregivers and/or medication administration observed that required judgment for necessity, dosage and/or effect. During an interview on 8/27/14 at 11:25 A.M., the Nurse Consultant (NC) and the Executive Director (ED) indicated QMA #2 should have observed Resident #413 take the medications. The ED indicated the resident had short term memory issues. A current policy titled "Medication Administration" undated, provided by the ED on 8/28/14 at 9:30 A.M., indicated "Residents of the facility shall receive medications as ordered by their physician to treat specific medical conditions...If incapable to self-administer medications with or without reminders, a licensed nurse or qualified medication aide shall be expected to administer medications as ordered by the physician...Also, the physician must concur, in the form of a physician's order, that the resident may self-administer medication(s). If the resident does not meet criteria for independent administration of the medication (s), medication administration will be executed by a licensed nurse or a qualified medication aide...."			

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R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to dispose of expired food items and dented cans and properly cover prepped food for 1 of 1 kitchen observations. This deficit practice had the potential to affect 31 of the 31 residents being served food from the kitchen. Findings include:	R000273	1.All expired foods and dented cans were immediately disposed of. The sandwiches were wrapped in plastic wrap. No residents were harmed. 2.All residents have the potential to be affected. The kitchen was checked to ensure it was free from expired foods, dented cans, and foods not covered appropriately. All kitchen staff will be in-serviced on Receiving Procedures for Food	09/12/2014

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	The kitchen tour was completed on 8/26/14 at 10 A.M., with the Kitchen Manager in attendance. 1. The reach-in cooler was observed to have the following items: A medium sized container labeled "Fresh Salad" with a use by date of 8/14/14 and a date marked on the lid with a black marker that indicated 7/23/14. A medium sized container labeled "Fresh Salad" with a use by date of 8/20/14 and a date marked on the lid with a black marker that indicated 7/23/14. A large container of "Homestyle Ranch Dressing" with a use by date of 6/13/14 and a date marked on the lid with a black marker that indicated 7/16/14. A large container of "Homestyle Ranch Dressing" with a use by date of 6/13/14 and a date marked on the lid with a black marker that indicated 7/10/14. A gallon container of "Mustard" with a use by date of 6/5/14 and a date marked on the lid with a black marker that indicated 6/17/14. 29 Turkey and Cheese sandwiches that had 2 pieces of brown colored paper		and Non Food items and Storage of Leftovers, (please see attachment G). 3.As a measure for ongoing compliance the Dietary Manager or designee will complete an audit weekly ongoing to ensure foods are stored and disposed of appropriately, (please see attachment H). 4.As a measure of quality assurance the Dietary manager or designee will complete said monitoring weekly ongoing. Should a deficient practice be observed, immediate corrective action will be taken. The plan ofcorrection will be revised accordingly, if warranted. TheAdministrator/Director or designee will monitor and sign off on the monitoring tools on a monthly basis ongoing.	

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	laying over the top of the tray covering the sandwiches. The brown paper was labeled as "Turkey and Cheese sandwiches for tonight's dinner and dated 8/26/14." The sides of the tray were observed to be uncovered and the sandwiches were sticking out from under the brown paper. 2. A reach-in freezer was observed to have a pie labeled as a "Quiche" and the label indicated it was prepared on 7/15/14 and was to be used by 7/21/14. 3. The storage area was observed to have the following dented cans on the shelves: 106 oz. (ounces) Diced Peaches 106 oz. Mandarin Oranges 6 lbs. (pounds) 10 oz. Salsa De Queso 6 lbs. 9 oz. Diced Pears 7 lbs. Apple filling or topping During an interview at that time the Kitchen Manager indicated the "Fresh Salad" was Chicken Salad. She indicated the Chicken Salad, Ranch Dressing, Mustard and Quiche should have been disposed of. She indicated the Chef had made the Quiche and placed the leftovers in the reach-in freezer. She indicated the Chef had made the sandwiches early this morning and she should have wrapped them in plastic wrap. The Kitchen Manager indicated she tried to return the			

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	dented cans for credit when the cans were delivered, but if she was unable then she had to dispose of the dented cans. A current policy titled "Receiving Procedures for Food & Non Food Items" dated 11/12/2008, was provided by the Executive Director (ED) on 8/28/14 at 9:30 A.M. The policy indicated, "Policy: All food and non-food items shall be checked upon receipt prior to departure of vendor delivery personnel. A credit shall be issued by the appropriate vendor if discrepancies exist. Procedure: ...2. Orders shall be inspected for the following items: ...c. Product is of good quality. Any items bearing evidence of the following shall be refused: ...5. Excessive dented cans...." A current policy titled "Storage of Leftovers" dated 11/12/2008, was provided by the ED on 8/28/14 at 9:30 A.M. The policy indicated, "Policy: It is the policy of this facility that food shall be stored according to acceptable sanitation standards. Procedure: ...2. Place leftovers in seamless containers with tight-fitting lids. 3. Label and date all containers with a 'Use By' date...6. Cooked food products should be discarded after three days...."			

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R000297	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure that medications were available from the Pharmacy for 2 of 8 residents whose medications were reviewed for availability from the Pharmacy. (Resident #102 and #413) Findings include: 1. The record for Resident #102 was reviewed on 8/26/14 at 3:46 P.M. Diagnoses included, but were not limited to, chronic pain, osteoarthritis, depression chronic obstructive pulmonary disease and peripheral arterial disease. A (MAR) Medication Administration Record dated August 2014, included, but were not limited to the following Physician orders: 5/21/14--Morphine Sulfate ER (Extended Release) (An opiate narcotic pain medication) 100 mg (milligrams) give	R000297	1.Resident #102 and #413 were not harmed. The physician and responsible party were notified for resident #102 and # 413. Resident # 102's prescription for Morphine Sulfate was filled promptly when the hard script was received by the pharmacy as per D.E.A. guidelines. Resident #413 received medications upon receipt from the pharmacy. The pharmacy and facility worked with the physician to obtain the prior authorization for the Brovana solution. 2.All residents utilizing medications have the potential to be affected. All medication carts were checked with the medication administration records to ensure all ordered medications were present. All nurses and QMA's were re-educated on the procedure for medications unavailable for administration, (please see attachment, D). 3.As a measure for ongoing compliance the DON or designee will review MAR's weekly ongoing to monitor for medication	09/12/2014

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	one tablet by mouth every 12 hours for diagnosis chronic pain. 8/27/14--Hold Morphine sulfate ER 100 mg until it arrives from the Pharmacy. The MAR dated August 2014, indicated that from 8/23/14 at 8 P.M. to 8/27/14 at 8 A.M., all the nurses and QMA's (Qualified Medication Aides) initials were circled on the 8 A.M. and 8 P.M. boxes for the the Morphine Sulfate order for a total of 10 doses of Morphine Sulfate not administered. The back of the MAR dated August 2014, indicated: 8/24/14 at 9 A.M., "Morphine Sulf ER 100 mg not available." 8/25/14 at 9 A.M., "morphine Sulf ER 100 mg not available pharmacy notified." 8/26/14 at 9 P.M., Morphine sulf ER 100 mg supply MD & pharmacy notified." 8/26/14 "Morphine Sulf 100 mg supply Exhausted pharmacy notified." 8/27/14 "Morphine Sulf 100 mg supply Exhausted pharmacy notified." An "Interdisciplinary Progress Note" dated 8/18/14 at 9 P.M., indicated "MD faxed for new Rx [prescription] for Norco [Hydrocodone]...." An "Interdisciplinary Progress Note"		unavailability, please see attachment I). Any medications noted to be unavailable will be addressed immediately to ensure the resident receives medications in a timely manner In order to prevent a disruption of their drug regimen. 4.As a measure of quality assurance the DON will complete the above described monitoring ongoing. Should a deficient practice beobserved, immediate corrective action will be taken. The plan of correctionwill be revised accordingly, if warranted. The Administrator/Director ordesignee will monitor and sign off on the monitoring tools on a monthly basis ongoing.	

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	dated 8/25/14 at 8 A.M., indicated "Resident is out of Morphine as of day 3. Resident needs new script, pharmacy notified, MD notified, D.O. N. notified, Family notified, Resident notified." An "Interdisciplinary Progress Note" dated 8/26/14 at 9 P.M., indicated "Resident out of Morphine MD aware pharmacy awaiting script hard copy before they can send per pharmacy...c/o [complaints of] pain scheduled Norco administered...." A "Consolidated Delivery Sheet" from the Pharmacy dated 8/27/14 at 8:30 P.M., indicated 60 Morphine Sulfate ER 100 mg tablets were accepted by LPN #3 from the Pharmacy delivery personnel. During an interview on 8/28/14 at 10:17 A.M., the Nurse Consultant indicated a circled medication on the MAR indicated the medication was not given. She indicated the resident's Morphine Sulfate 100 mg was not delivered until 8/27/14 because the Pharmacy needed a hard script for the medication and the Physician continued to fax the script to the Pharmacy. She indicated the facility would communicate to the Physician that the Pharmacy needed the script and he would fax it, when the Pharmacy needed a hard copy sent to them. She indicated			

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	someone from the facility communicated to the Physician he needed to write a hard script and leave it at the facility and the facility would place it in the tote to send to the Pharmacy. 2. The record for Resident #413 was reviewed on 8/27/14 at 12:32 P.M. Diagnoses included, but were not limited to, cerebrovascular accident, chronic atrial fibrillation, diabetes mellitus type II, hypertension, congestive heart failure, vascular dementia, depression, and osteoarthritis. A (MAR) Medication Administration Record dated July 2014, included, but were not limited the following Physician orders: 7/18/14--Multivitamin (A supplement medication) give one tablet by mouth daily for diagnosis of supplement. 7/18/14--Sertraline HCL (Hydrochloride) (An Antidepressant medication) 50 mg (milligrams) give one tablet by mouth daily for diagnosis of depression / anxiety. 7/18/14--Nicotine (A patch to stop nicotine cravings) Patch 7 mg/24 hours apply to skin every day. Remove old patch before applying new patch for diagnosis smoking cessation. 7/18/14--Brovana (A bronchodilater inhaler medication) 15 mcg (micrograms)			

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	/ 2 ml (milliliters) solution Inhale 15 mcg two times a day for diagnosis Emphysema (Order changed on 7/29/14) 7/18/14--Spiriva 18 mcg Handihaler device (A bronchodilater inhaler medication) Inhale contents of one capsule via HHN (Handihaler nebulizer) daily for diagnosis of empysema. 7/18/14--Duoneb Solution (A bronchodilater medication) 0.5-3 (2.5) mg give one vial via nebulizer two times a day for diagnosis empysema. (Order changed on 7/29/14) 7/18/14--Medications may be started when available from Pharmacy. 7/23/14--Hold Brovana Solution 15 mcg twice a day until available from pharmacy. 7/29/14--Brovana Solution use 1 vial via nebulizer twice a day as needed for shortness of breath. 7/29/14--Duoneb use one vial nebulizer every six hours as needed for shortness of breath. The MAR dated July 2014, indicated the nurses or QMA's initials were circled on the following dates for the following medications: Multivitamin-7/19/14 and 7/20/14 so the resident missed 2 doses of medication. Nicotine Patch--7/19/14 through 7/21/14 so the resident missed 3 doses of medication			

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		A. BUILDING 00 B. WING	08/28/2014

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	Spiriva--7/19/14 through 7/21/14 so the resident missed 3 doses of medication. Brovana--7/18/14 through 7/23/14 when the medication was placed on hold until available on 7/28/14 so the resident missed 14 doses of medication. Duoneb--7/18/14 through 7/22/14 so the resident missed 10 doses of medication. The back of the MAR's dated July 2014, indicated the following: 7/18/14 at 9 P.M., "Duoneb [sign for zero] supply not given." 7/18/14 at 9 P.M., "Brovana [sign for zero] supply not given." 7/21/14 at 8 A.M., "Multivitamin p.o. supply Exhausted pharmacy notified." 7/21/14 at 8 A.M., "Spriva [sic] p.o. supply Exhausted pharmacy notified." 7/21/14 at 9 P.M., "Brovana [sign for zero] supply ND notified / Pharm notified not given." 7/21/14 at 9 P.M., "Duoneb [sign for zero] MD notified." 7/22/14 at 9 P.M., "Brovana [sign for zero] supply MD notified." 7/22/14 at 9 P.M., "Duoneb [sign for zero] supply MD notified." 7/23/14 at 9 P.M., "Brovana [sign for zero] supply Medication ordered Held my MD." 7/23/14 at 9 P.M., "Duoneb [sign for zero] supply medication ordered Held by MD.			

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	An "Interdisciplinary Progress Note" dated 7/23/14 at 3 P.M., indicated "Res Brovana medication not available, Pharmacy called, Pharmacist stated that medication requires a prior authorization. MD notified." A "Consolidated Delivery Sheet" from the Pharmacy dated 7/21/14, indicated that the resident's Multivitamin, Nicotine Patch, Spiriva Inhaler, and Sertraline medications were received from the Pharmacy on this day at 8:30 P.M., by LPN #3. A "Consolidated Delivery Sheet" from the Pharmacy dated 7/28/14, indicated that the resident's Brovana Solution for nebulizer treatments were received from the Pharmacy on this day at 8:30 P.M., by LPN #3. During an interview on 8/28/14 at 10:30 A.M., the Nurse Consultant indicated the resident was admitted to the facility late on a Friday afternoon and the Pharmacy did not deliver on Saturdays and Sundays and that was why the resident did not get her medications delivered until 7/21/14. She indicated every resident in the facility had an order that medications may be started when they were available from the Pharmacy. She indicated the			

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	resident had brought some medications with her from the other facility she came from, but she must have exhausted her supply. She indicated the facility's back up plan was that for emergency drugs only the resident's could obtain medications from the (Name of Pharmacy). The Nurse Consultant indicated the facility did not have an EDK (Emergency Drug Kit) because it was an Assisted Living facility. The Nurse Consultant indicated the resident needed a Prior Authorization (PA) for the Brovan Solution and that was the reason she had not received it until 7/28/14. She indicated the facility notified the Physician a PA was needed, but the Pharmacy was responsible for obtaining the PA. A current policy titled "Medications Unavailable for Administration" undated, provided by the Executive Director on 8/28/14 at 9:30 A.M., indicated "...In the course of passing ordered medications, should a medication be out of supply or unavailable for administration, the licensed nurse or QMA is responsible to do the following:.. -consider the immediate need for the medication, either due to needed initiation of treatment (e.g., in the case of an antibiotic) or due to maintaining a therapeutic blood level (e.g., in the case of anti-seizure			

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	medications or psychoactive medications0. If the medication is needed immediately, check the EDK and, if available, obtain the dose from the EDK for administration then proceed to contact the pharmacy for delivery of supply. -if when contacting the pharmacy you are informed of a situation which will delay or complicate delivery (for example, the medication has recently been filled and it is too soon for it to be refilled; the medication is not "covered" etc.) contact administrative nursing/DON to determine how to proceed and to ensure that you have notified them that the resident did not (or will not) receive the medication as ordered until further corrective action is taken...If there will be a significant delay (e.g., 2-3 omitted doses), we must contact the physician and notify him/her of the unavailability of the ordered medication to provide him/her with the opportunity to order an alternate medication (which may be in the EDK or have no complications with delivery---for example, may be a "covered" medication)...."			

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R000305	410 IAC 16.2-5-6(f)(1-3) Pharmaceutical Services - Noncompliance (f) Residents may use the pharmacy of their choice for medications administered by the facility, as long as the pharmacy: (1) complies with the facility policy receiving, packaging, and labeling of pharmaceutical products unless contrary to state and federal laws; (2) provides prescribed service on a prompt and timely basis; and (3) refills prescription drugs when needed, in order to prevent interruption of drug regimens. Based on interview and record review, the facility failed to ensure that medications provided to residents in a timely manner and in order to prevent a disruption of their drug regimen for 2 of 8 residents reviewed for timeliness of medication delivery from the Pharmacy. (Resident #102 and #413) Findings include: 1. The record for Resident #102 was reviewed on 8/26/14 at 3:46 P.M. Diagnoses included, but were not limited to, chronic pain, osteoarthritis, depression chronic obstructive pulmonary disease and peripheral arterial disease. A (MAR) Medication Administration Record dated August 2014, included, but were not limited to the following Physician orders: 5/21/14--Morphine Sulfate ER (Extended	R000305	1.Resident #102 and #413 were not harmed. The physician and responsible party were notified for resident #102 and # 413. Resident # 102's prescription for Morphine Sulfate was filled promptly when the hard script was received by the pharmacy as per D.E.A. guidelines. Resident #413 received medications upon receipt from the pharmacy. The pharmacy and facility worked with the physician to obtain the prior authorization for the Brovana solution. 2.All residents utilizing medications have the potential to be affected. All medication carts were checked with the medication administration records to ensure all ordered medications were present. All nurses and QMA's were re-educated on the procedure for medications unavailable for administration, (please see attachment, D). 3.As a measure for ongoing compliance the DON or designee	09/12/2014

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	Release) (An opiate narcotic pain medication) 100 mg (milligrams) give one tablet by mouth every 12 hours for diagnosis chronic pain. 8/27/14--Hold Morphine sulfate ER 100 mg until it arrives from the Pharmacy. The MAR dated August 2014, indicated that from 8/23/14 at 8 P.M. to 8/27/14 at 8 A.M., all the nurses and QMA's (Qualified Medication Aides) initials were circled on the 8 A.M. and 8 P.M. boxes for the the Morphine Sulfate order for a total of 10 doses of Morphine Sulfate not administered. The back of the MAR dated August 2014, indicated: 8/24/14 at 9 A.M., "Morphine Sulf ER 100 mg not available." 8/25/14 at 9 A.M., "morphine Sulf ER 100 mg not available pharmacy notified." 8/26/14 at 9 P.M., Morphine sulf ER 100 mg supply MD & pharmacy notified." 8/26/14 "Morphine Sulf 100 mg supply Exhausted pharmacy notified." 8/27/14 "Morphine Sulf 100 mg supply Exhausted pharmacy notified." An "Interdisciplinary Progress Note" dated 8/25/14 at 8 A.M., indicated "Resident is out of Morphine as of day 3. Resident needs new script, pharmacy		will review MAR's weekly ongoing to monitor for medication unavailability (please see attachment I). Any medications noted to be unavailable will be addressed immediately to ensure the resident receives medications in a timely manner in order to prevent a disruption of their drug regimen. 4.As a measure of quality assurance the DON will complete the above described monitoring ongoing. Should a deficient practice be observed, immediate corrective action will be taken. The plan of correction will be revised accordingly, if warranted. The Administrator/Director or designee will monitor and sign off on the monitoring tools on a monthly basis ongoing.	

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	notified, MD notified, D.O. N. notified, Family notified, Resident notified." An "Interdisciplinary Progress Note" dated 8/26/14 at 9 P.M., indicated "Resident out of Morphine MD aware pharmacy awaiting script hard copy before they can send per pharmacy...c/o [complaints of] pain scheduled Norco administered...." A "Consolidated Delivery Sheet" from the Pharmacy dated 8/27/14 at 8:30 P.M., indicated 60 Morphine Sulfate ER 100 mg tablets were accepted by LPN #3 from the Pharmacy delivery personnel. Resident #102 signed a form titled (Name of Pharmacy) "Pharmacy Consent Form" dated 7/12/13, that indicated she had initialed by a line that included, but was not limited to the following: "I acknowledge that I have been provided with a copy of the Pharmacy Service Permission Form." A document titled (Name of Pharmacy) "Pharmacy Services Permission Form" indicated, "The pharmacy services as provided in this facility have been explained to me and I wish to take advantage of this service...I further understand that the pharmacy that I designate must provide sufficient services			

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	to adequately protect the safety of the patient and must properly serve the needs of the facility...Additionally, the pharmacy must provide 24 hour emergency prescription service (410 IAC 16.2-3-8 Sec.8). Such arrangements must be made in writing from the providing pharmacy...Please designate your pharmacy selection by initializing your choice on the Pharmacy Consent Form and signing the consent form...." During an interview on 8/28/14 at 10:17 A.M., the Nurse Consultant indicated a circled medication on the MAR indicated the medication was not given. She indicated the resident's Morphine Sulfate 100 mg was not delivered until 8/27/14 because the Pharmacy needed a hard script for the medication and the Physician continued to fax the script to the Pharmacy. She indicated the facility would communicate to the Physician that the Pharmacy needed the script and he would fax it, when the Pharmacy needed a hard copy sent to them. She indicated someone from the facility communicated to the Physician he needed to write a hard script and leave it at the facility and the facility would place it in the tote to send to the Pharmacy. 2. The record for Resident #413 was reviewed on 8/27/14 at 12:32 P.M.			

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	Diagnoses included, but were not limited to, cerebrovascular accident, chronic atrial fibrillation, diabetes mellitus type II, hypertension, congestive heart failure, vascular dementia, depression, and osteoarthritis. A (MAR) Medication Administration Record dated July 2014, included, but were not limited the following Physician orders: 7/18/14--Multivitamin (A supplement medication) give one tablet by mouth daily for diagnosis of supplement. 7/18/14--Sertraline HCL (Hydrochloride) (An Antidepressant medication) 50 mg (milligrams) give one tablet by mouth daily for diagnosis of depression / anxiety. 7/18/14--Nicotine (A patch to stop nicotine cravings) Patch 7 mg/24 hours apply to skin every day. Remove old patch before applying new patch for diagnosis smoking cessation. 7/18/14--Brovana (A bronchodilater inhaler medication) 15 mcg (micrograms) / 2 ml (milliliters) solution Inhale 15 mcg two times a day for diagnosis Emphysema (Order changed on 7/29/14) 7/18/14--Spiriva 18 mcg Handihaler device (A bronchodilater inhaler medication) Inhale contents of one capsule via HHN (Handihaler nebulizer) daily for diagnosis of empysema.			

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	7/18/14--Duoneb Solution (A bronchodilater medication) 0.5-3 (2.5) mg give one vial via nebulizer two times a day for diagnosis empysema. (Order changed on 7/29/14) 7/18/14--Medications may be started when available from Pharmacy. 7/23/14--Hold Brovana Solution 15 mcg twice a day until available from pharmacy. 7/29/14--Brovana Solution use 1 vial via nebulizer twice a day as needed for shortness of breath. 7/29/14--Duoneb use one vial nebulizer every six hours as needed for shortness of breath. The MAR dated July 2014, indicated the nurses or QMA's initials were circled on the following dates for the following medications: Multivitamin-7/19/14 and 7/20/14 so the resident missed 2 doses of medication. Nicotine Patch--7/19/14 through 7/21/14 so the resident missed 3 doses of medication Spiriva--7/19/14 through 7/21/14 so the resident missed 3 doses of medication. Brovana--7/18/14 through 7/23/14 when the medication was placed on hold until available on 7/28/14 so the resident missed 14 doses of medication. Duoneb--7/18/14 through 7/22/14 so the resident missed 10 doses of medication.			

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	The back of the MAR's dated July 2014, indicated the following: 7/18/14 at 9 P.M., "Duoneb [sign for zero] supply not given." 7/18/14 at 9 P.M., "Brovana [sign for zero] supply not given." 7/21/14 at 8 A.M., "Multivitamin p.o. supply Exhausted pharmacy notified." 7/21/14 at 8 A.M., "Spriva [sic] p.o. supply Exhausted pharmacy notified." 7/21/14 at 9 P.M., "Brovana [sign for zero] supply ND notified / Pharm notified not given." 7/21/14 at 9 P.M., "Duoneb [sign for zero] MD notified." 7/22/14 at 9 P.M., "Brovana [sign for zero] supply MD notified." 7/22/14 at 9 P.M., "Duoneb [sign for zero] supply MD notified." 7/23/14 at 9 P.M., "Brovana [sign for zero] supply Medication ordered Held my MD." 7/23/14 at 9 P.M., "Duoneb [sign for zero] supply medication ordered Held by MD. An "Interdisciplinary Progress Note" dated 7/23/14 at 3 P.M., indicated "Res Brovana medication not available, Pharmacy called, Pharmacist stated that medication requires a prior authorization. MD notified."			

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	A "Consolidated Delivery Sheet" from the Pharmacy dated 7/21/14, indicated that the resident's Multivitamin, Nicotine Patch, Spiriva Inhaler, and Sertraline medications were received from the Pharmacy on this day at 8:30 P.M. by LPN #3. A "Consolidated Delivery Sheet" from the Pharmacy dated 7/28/14, indicated that the resident's Brovana Solution for nebulizer treatments were received from the Pharmacy on this day at 8:30 P.M. by LPN #3. Resident #413 signed a form titled (Name of Pharmacy) "Pharmacy Consent Form" dated 7/12/13, that indicated she had initialed by a line that included, but was not limited to the following: "I acknowledge that I have been provided with a copy of the Pharmacy Service Permission Form." A document titled (Name of Pharmacy) "Pharmacy Services Permission Form" indicated, "The pharmacy services as provided in this facility have been explained to me and I wish to take advantage of this service...I further understand that the pharmacy that I designate must provide sufficient services to adequately protect the safety of the patient and must properly serve the needs			

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	of the facility...Additionally, the pharmacy must provide 24 hour emergency prescription service (410 IAC 16.2-3-8 Sec.8). Such arrangements must be made in writing from the providing pharmacy...Please designate your pharmacy selection by initializing your choice on the Pharmacy Consent Form and signing the consent form...." During an interview on 8/28/14 at 10:30 A.M., the Nurse Consultant indicated the resident was admitted to the facility late on a Friday afternoon and the Pharmacy did not deliver medications on Saturdays and Sundays and that was why the resident did not get her medications delivered until 7/21/14. She indicated every resident in the facility had an order that medications may be started when they were available from the Pharmacy. She indicated the resident had brought some medications with her from the other facility she came from, but she must have exhausted her supply. She indicated the facility's back up plan was that for emergency drugs only the resident's could obtain medications from the (Name of Pharmacy -back-up). The Nurse Consultant indicated the resident needed a Prior Authorization (PA) for the Brovan Solution and that was the reason she had not received it until 7/28/14. She indicated the facility notified the			

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	Physician a PA was needed, but the Pharmacy was responsible for obtaining the PA. During an interview on 8/28/14 at 11:15 A.M., the Executive Director indicated each resident was able to choose what Pharmacy they wanted to order their medications from. He indicated both residents had requested (Name of the Pharmacy) to fill their medications. He indicated the residents sign an agreement with the Pharmacy to have their medications filled. The facility did not have a contract with the Pharmacy.			